

Nevada Department of  
Health and Human Services  
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH



# Comprehensive Gaps Analysis of Behavioral Health Services

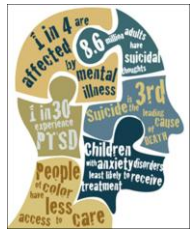
January 29, 2014

Behavioral Health and Wellness Council

Presented by:  
*Kelly Marschall, MSW*



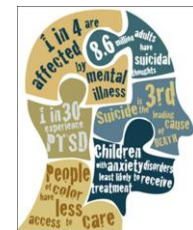
# Purpose of the Report



*The purpose of the gaps analysis report was to forward the efforts of the state to implement a system of care as Nevada integrates Public and Behavioral Health by identifying gaps in the service delivery system.*



# Content of the Report



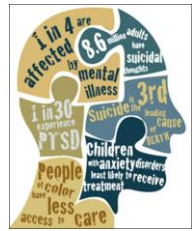
The gaps analysis report includes a mapping and analysis of behavioral health services in Nevada using the SAMHSA strategic prevention framework. (March – September 2013)

The report summarizes:

- The current behavioral health service delivery system at the state and local level at a point in time,
- Unmet needs related to behavioral health, and
- Opportunities and recommendations for systems improvement.



# Method of the Report



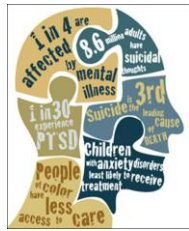
Conducting a gaps analysis is simplified within a defined system of stable service delivery components where consistent and reliable longitudinal data are available for analysis. The system at the point in time of the analysis is compared to the defined system as intended.

The variance between the two systems and the outcomes sought versus achieved are used to identify gaps.

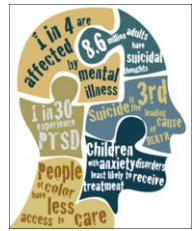
*Unfortunately, these circumstances did not exist during the development of this report.*



# Method of the Report



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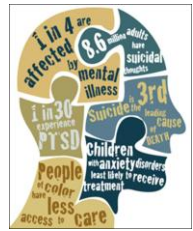


A combination of qualitative and quantitative data was used to complete the gaps analysis.

- Qualitative data such as key informant interviews, group meeting participation, and consumer surveys were used to gather input from a variety of stakeholders to discern the resources in use and the gaps related to behavioral health in their area of concern.
- Quantitative data such as estimated need, service provider capacity, and utilization rates were collected and analyzed. Research from US sources was utilized to calculate unmet needs.



# Context of the Report



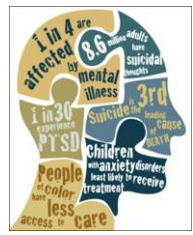
This study took place during a significant time of transition and turmoil within the State of Nevada related to behavioral health.

- The state was preparing for integration efforts across multiple state departments.
- Biennial legislature was in session, tasked with budget passage.
- The state became the target of public scrutiny as a result of a number of issues related to the care and treatment of behavioral health clients.



# Context of the Report:

## Integration Efforts



Integration of Mental Health and Developmental Services (MHDS) and the Health Division into the Division of Public and Behavioral Health (DPBH) became official on July 1, 2013.

The integration efforts are a work in progress:

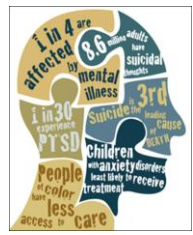
- Uniform policies and procedures do not exist system wide.
- Staffing resources and service provision continue to function in silos.
- Data to quantify services provided and identify ongoing need are not reliably captured.





# Context of the Report:

## Legislative Session

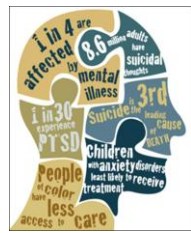


- Integration required passage of the 2013-2015 budget by a legislature that was in session from February to June 2013. Excessively long wait times for clients at the state operated forensic facility
- The required presence of Division leadership during the legislative session further impacted the ability to move forward with implementation.
- Regulations that require separate budgets for SNAMHS, NNAMHS and RCSS created inflexibility to meet the changing needs of the system as a whole.



# Context of the Report:

## Public Scrutiny

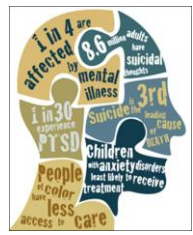


From March through August 2013, the State of Nevada faced a number of difficult circumstances surrounding the operations of publicly supported behavioral health services throughout the state.

- Allegations of improper discharge practices
- Excessively long wait times for clients at the state operated forensic facility
- Infractions within state psychiatric facilities that could jeopardize their Center for Medicare & Medicaid Services (CMS) certification



# Limitations of the Report:

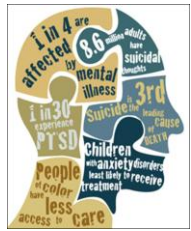


Several limitations are important to consider regarding the content of the report:

- Systems are constantly in flux and this report describes a point in time that doesn't include changes or events that occurred after September 2013
- Comparison data for penetration rates and financing include state data reported in multiple manners by states
- Federal expenditure reports only include Medicaid funds to the extent that they flow through the state mental health authority; states may bypass the SMHA with some Medicaid funds for mental health services
- While census data was used for projections and included undocumented individuals, little is known about the needs of that subpopulation



# Description of Current Service System



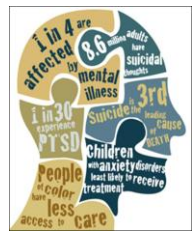
The behavioral health system in Nevada is comprised of federal, state and local resources that operate under a variety of funding sources, priorities and mandates.

Services throughout the state differ based on target population, geographic region and funding source.

As a result, there are often different challenges for persons seeking behavioral health assistance based on services available and where they are sought.



# Description of Current Service System: Primary Provider



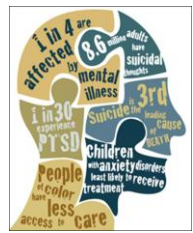
The most significant provider of public behavioral health services in Nevada is the Division of Public and Behavioral Health (DPBH).

There are 4 service delivery systems that operate within DPBH to provide behavioral health care:

- Northern Nevada Adult Mental Health Services
- Southern Nevada Adult Mental Health Services
- Rural Counseling and Supportive Services; and
- Lake's Crossing.



# Description of Current Service System: Financing Behavioral Health



The table below demonstrates that Nevada's per capita behavioral health spending has and continues to be significantly lower than the national average (Foundation, 2013).\*

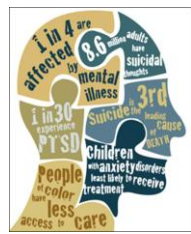
\*updated numbers to be provided by DHHS

PER CAPITA BEHAVIORAL HEALTH EXPENDITURES		FFY04	FFY05	FFY06	FFY07	FFY08	FFY09	FFY10
Nevada	\$ per capita	\$54	\$63	\$61	\$79	\$81	\$64	\$68
	Rank	40	39	42	33	36	41	43
United States	\$ per capita	\$93	\$100	\$104	\$113	\$121	\$123	\$121

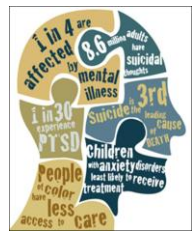




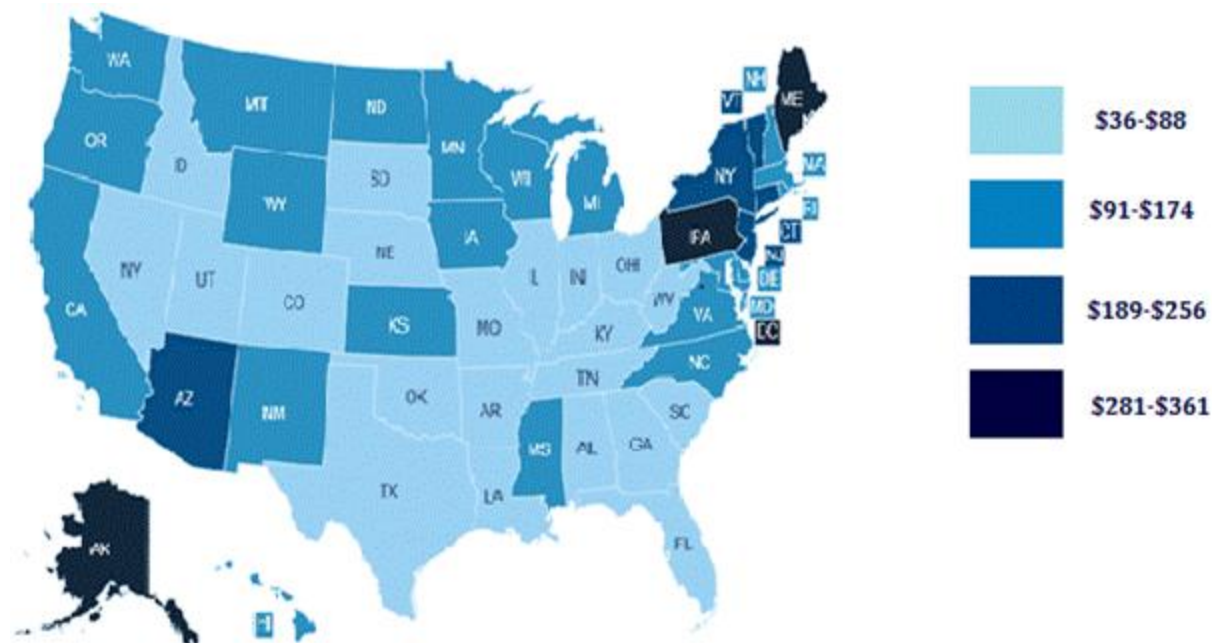
# Description of Current Service System: Financing Behavioral Health



# Description of Current Service System: Financing Services

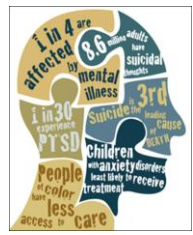


The following map illustrates how Nevada compares to the rest of the nation in per-person behavioral health spending for FY2010 (Foundation, 2013).





# Description of Current Service System: Missed Opportunities



Nevada has missed a number of opportunities over the years to strengthen its behavioral health system in response to previous reforms.

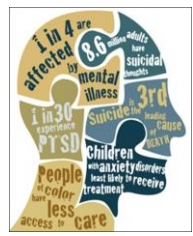
These opportunities go back to the adoption of the Community Mental Health Act of 1963 (CMHA), some 50 years ago.

*“Officials have known about solutions for decades, economic recessions and budgetary constraints have kept them from fully and consistently implementing mental health programming.”*

The Las Vegas Sun,  
August 2013



# Description of Current Service System: 50 Year Retrospective



**1963:** The Community Mental Health Act (promoting de-institutionalization) passed under the administration of President John F. Kennedy, which paved the way for southern Nevada to develop its first mental health outpatient clinics.<sup>1</sup>

1991-92: State mental health budget plummeted again when the budget was cut by a crippling 12%.<sup>3</sup>

1992: Congress established Substance Abuse and Mental Health Services Administration (SAMHSA).

1995: Article published in the *Nevada Public Affairs Review* traced the deterioration in Nevada mental health services over more than a decade.<sup>3</sup>

1996: National average of state hospital psychiatric beds per 100,000 population was 33. Clark County under-bedded with 4.5 beds per 100,000.

2004: Thom Reilly, County Manager and CEO for Clark County, declared a state of emergency. While the news might have been startling to the public, the problem had become chronic and all too familiar to those working in the Nevada public mental health system. In fact, it had been growing for more than a decade.<sup>1</sup>

2006: A NAMI report identified some of Nevada's urgent needs: overflowing emergency rooms, particularly in Las Vegas; implementation of evidence based practices on Act programs; supportive housing options especially in rural areas.<sup>6</sup>

2006-07: Assembly Bill (AB) 175 added \$12.6 million for mental health crisis services and mental health courts.

2013: Rawson-Neal in Southern Nevada loses its certification from the Commission of Joint Accreditation, a nonprofit oversight agency for hospitals, and is in jeopardy of losing federal funding if it fails its next inspection by the U.S. Centers of Medicare and Medicaid.

2013: Nevada's Governor proposes and legislature approves opting into the Affordable Care Act.

1963

1970

1980

1990

2000

2010

2013

1983: Facing financial exigency, funding cut for mental health services.

1979: In one of the very few historic reviews of mental health services in Nevada, a report identified three characteristics of Nevada's system: (1) marked fluctuations in service capacity; (2) a lack of public supervision or independent professional review of mental health programs; and (3) absence of long-term planning.<sup>2</sup>

1975: First public psychiatric hospital in Southern Nevada opened its doors.

2003: The patient to psychiatrist ratio in Nevada was approximately 700:1.<sup>5</sup>

Late 90s: State mental health services have never fully recovered from the precipitous decline of the prior decade. Including a rather unique statewide delivery structure in which the state has been the sole provider and primary source of funding for public agencies delivering mental health services. Population explosion led to a dramatic increase in consumers needing mental health services.<sup>4</sup>

1999: *Olmstead*, established a constitutional mandate to provide mental health treatment to individuals in the least restrictive environment.<sup>4</sup>

1998: Division's name changed to "Mental Health and Developmental Services."

2007-12: \$80 million in cuts to mental health budget.<sup>7</sup>

2007-11: Staff positions in the state's mental health division decreased by 364.<sup>7</sup>

2007-11: Clark County's inpatient bed capacity reduced from 234 beds to 190.

2013: San Francisco files a class-action lawsuit against the State of Nevada alleging that its primary psychiatric hospital bussed mentally ill patients to its city limits.

2013: Clark County sues Lake's Crossing, Nevada's only facility for criminals who are diagnosed mentally ill, for failing to provide court-ordered treatment.

<sup>1</sup>Landreth, K., Brandenburg, C., & Gottschalk, S. (2004). *Mental Health Problems and Needs in Nevada*.

<sup>2</sup>Pillard, E. (1979). "Nevada's Treatment of the Mentally Ill," *Nevada Historical Society Quarterly*, Vol. XXII.

<sup>3</sup>Lahren B. (1995). *Nevada's Mental Health System, 1960 to 1994, With Recommendations for Improvement*.

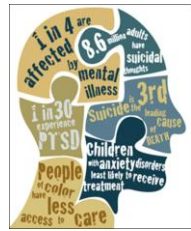
<sup>4</sup>State Profile Highlights (2005). National Association of State Mental Health Program Directors Research Institute, Inc. (NR) No. 05-08. November 2005.

<sup>5</sup>Office of Suicide Prevention (2012) *Nevada Suicide Prevention Plan 2007-2012*. Department of Health and Human Services.

<sup>6</sup>"Grading the States: A Report on America's Health Care System for Serious Mental Illness," NAMI (2006)

<sup>7</sup>Doughman A. (2013). *Decay in Nevada's Mental Health System Goes Beyond Rawson-Neal*. Las Vegas Sun.

# Profile of Current Behavioral Health Consumers



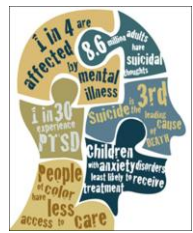
The Report examined the profile of behavioral health consumers based on:

- Age,
- Gender and,
- Race.

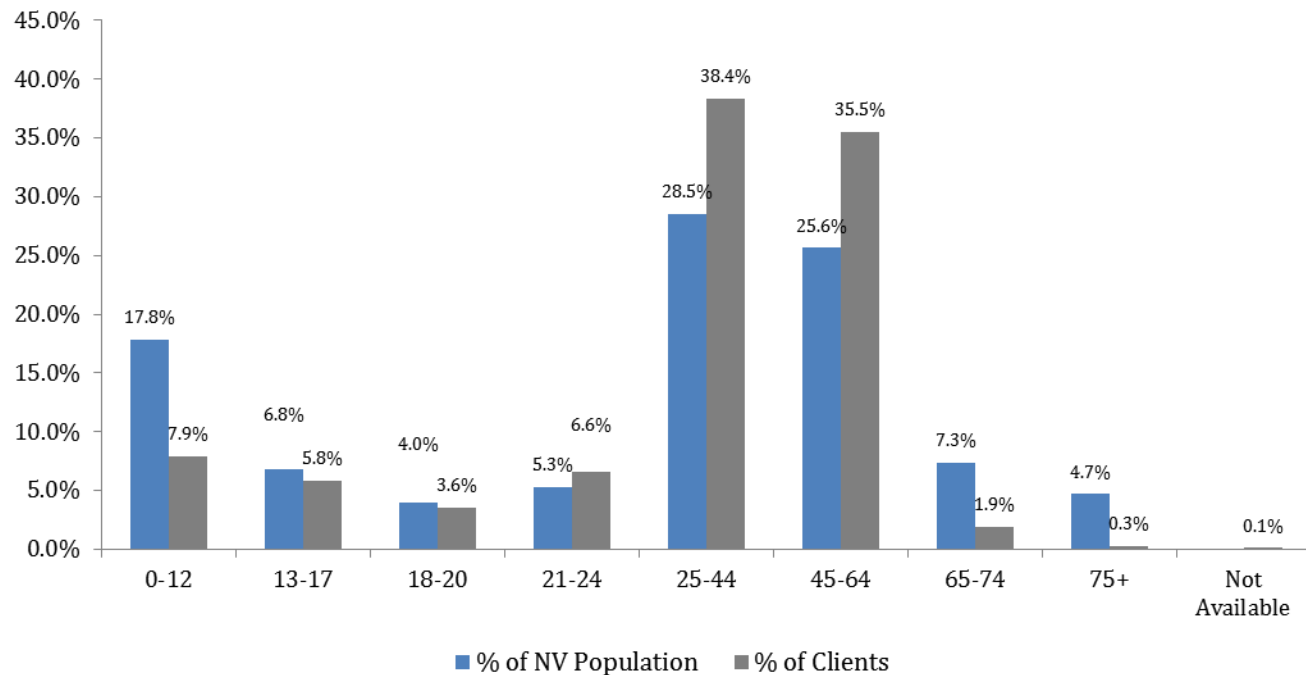
Additionally, penetration rates were explored to identify how well the state of Nevada was reaching consumers in need of behavioral health services.



# Profile of Current Behavioral Health Consumers: Age

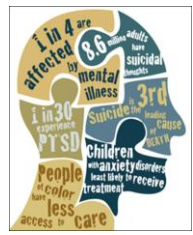


In Nevada, the largest category of consumers accessing care is between the ages of 25-44, representing 38% of the service population. This is followed by consumers between the ages of 45-65, representing 35% of the service population.

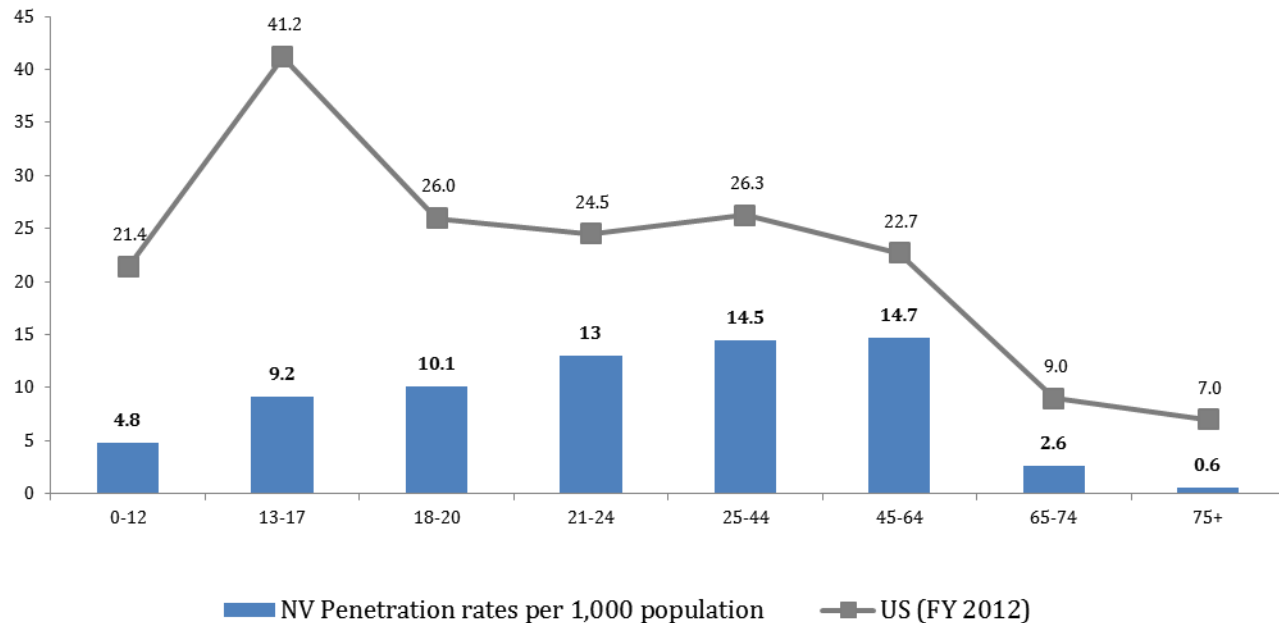




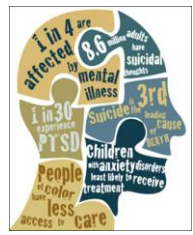
# Profile of Current Behavioral Health Consumers: Age



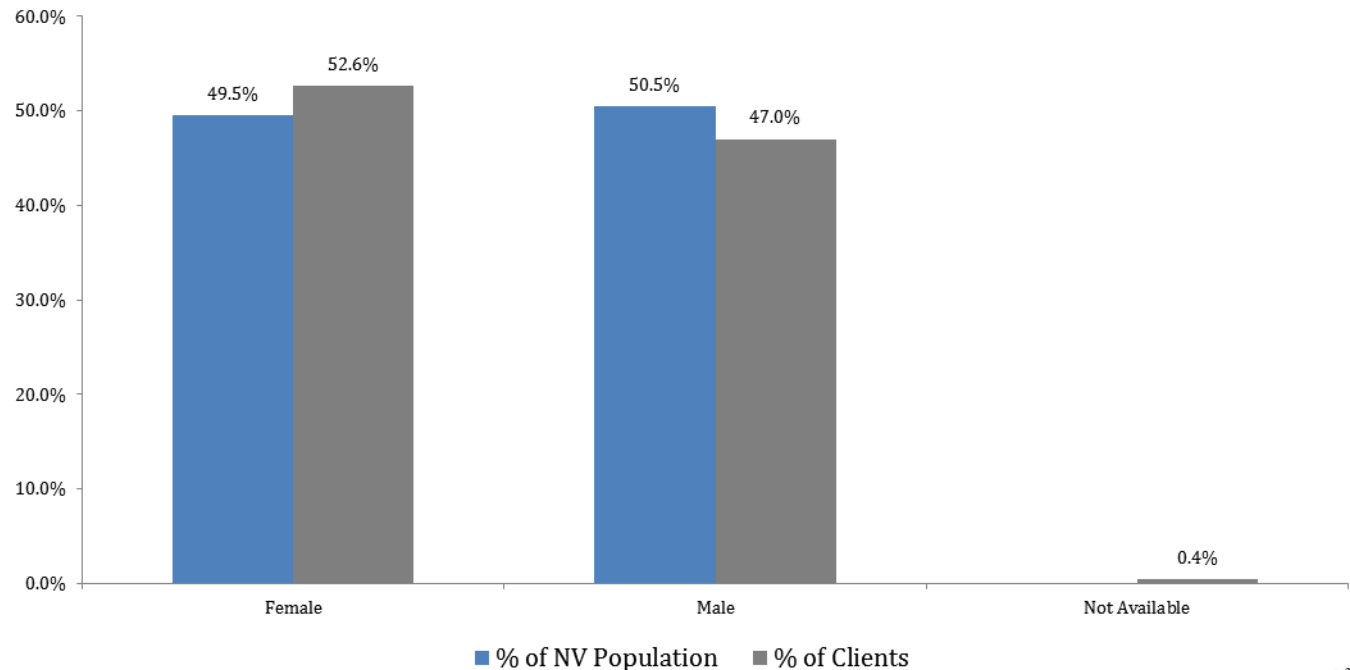
Penetration Rates indicate that Nevada serves one child (ages 0-12) for every four, on average, served nationally and one senior (ages 75+) to every 12 served nationally.



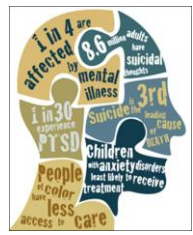
# Profile of Current Behavioral Health Consumers: Gender



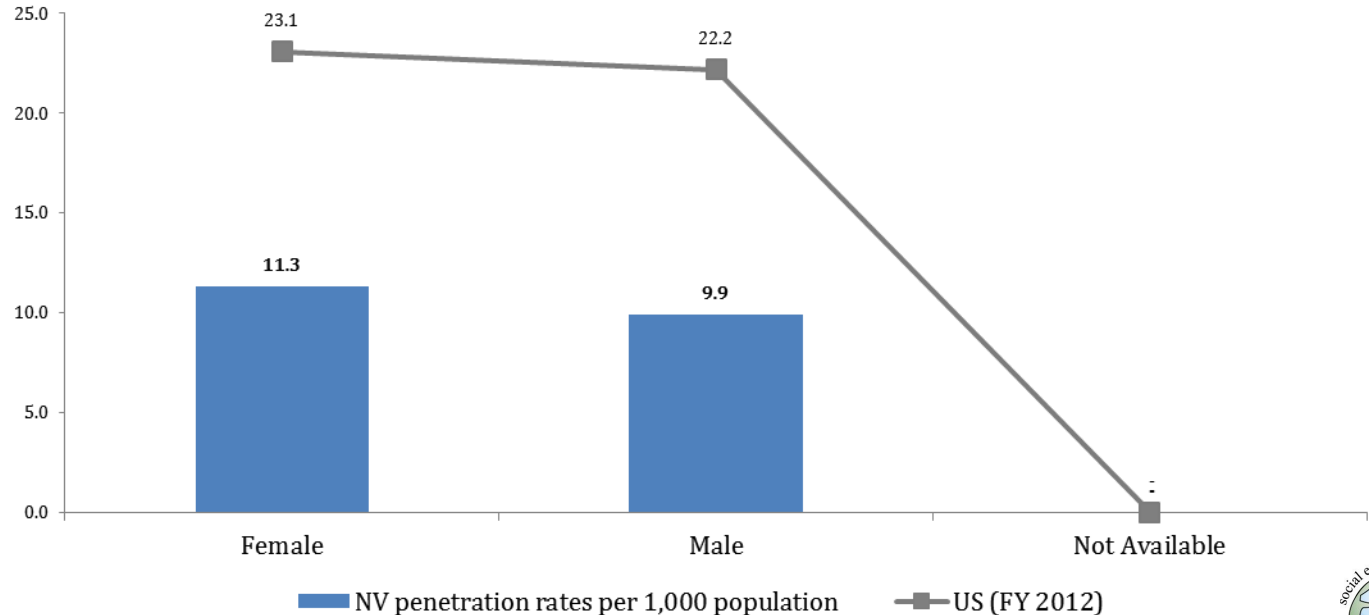
Female consumers make up the largest demographic of individuals accessing care, representing 53% of the service population. Male consumers represent the remaining 47% of the service population.



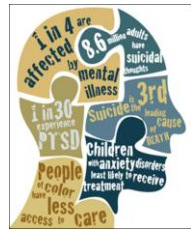
# Profile of Current Behavioral Health Consumers: Gender



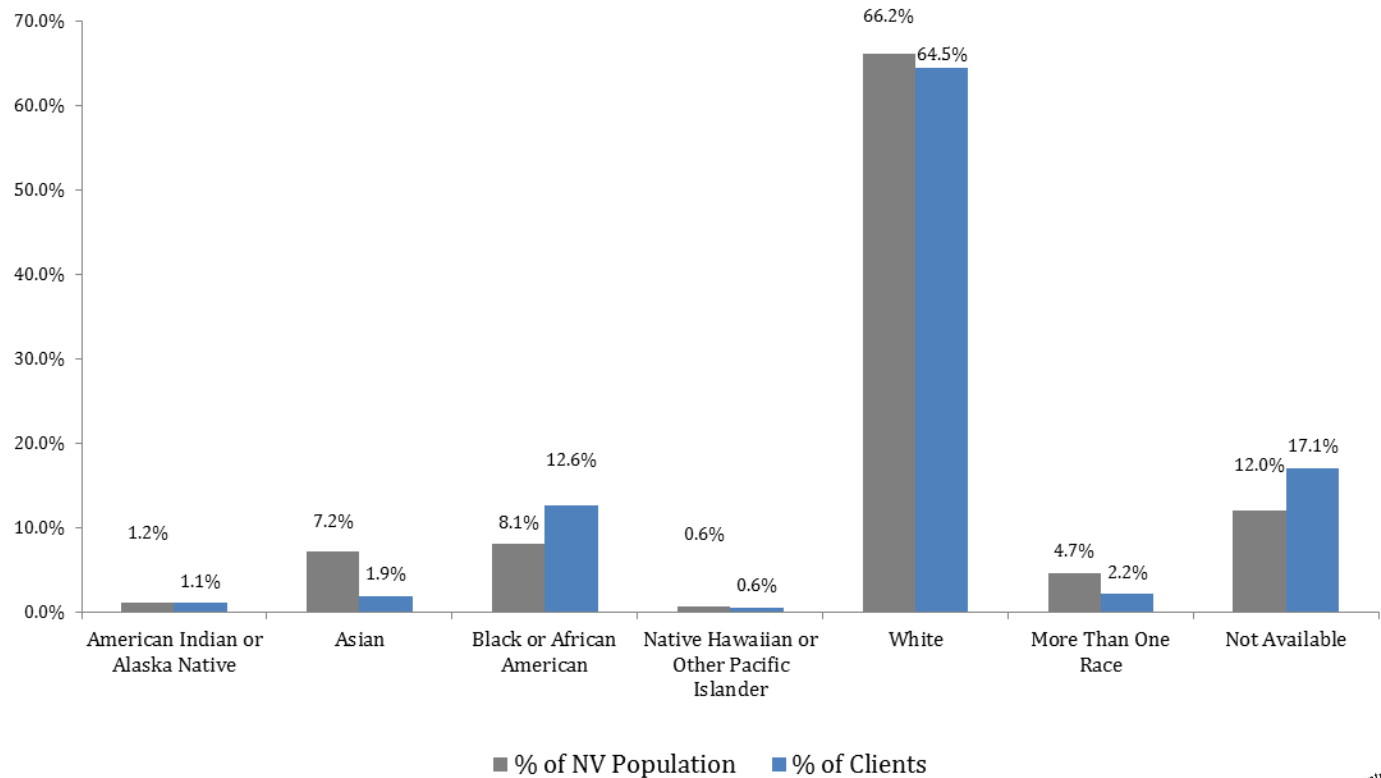
Nationally averaged penetration rates for females account for 23.1 persons per 1,000 people in the population, compared to 11.3 persons in Nevada. Nationally averaged penetration rates of services to men, (22.1 per 1,000) also exceed Nevada's rate of 9.9 per 1,000.



# Profile of Current Behavioral Health Consumers: Race

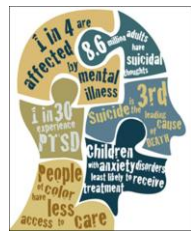


Behavioral health consumers served largely reflect the racial demographics of the state.



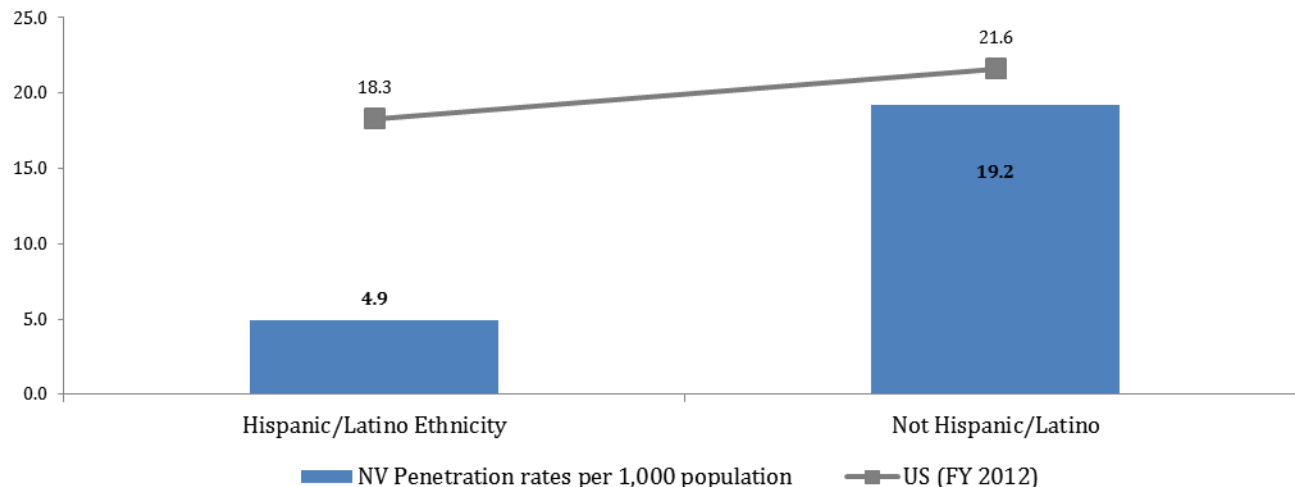


# Profile of Current Behavioral Health Consumers: Ethnicity

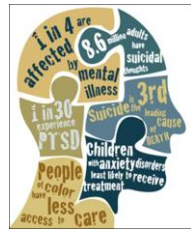


While 26.5% of the population in Nevada is Hispanic/Latino, they only represent 12.5% of those served.

Additionally, penetration rates reveal that Nevada reaches a significantly lower percentage of Hispanic consumers needing services when compared to national averages.



# Unmet Need



A multi-step formula was used to establish an estimate of unmet need related to behavioral health services.

**Step 1:** To identify the population in Nevada that need behavioral health support and are eligible to receive it through public provisions, the following formula was used:

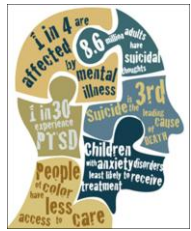
$$\left( \begin{array}{c} \text{2010} \\ \text{CENSUS} \\ \text{DATA} \end{array} \right) \times \begin{array}{c} \% \text{ OF POPULATION} \\ \text{ELIGIBLE FOR} \\ \text{MEDICAID IN} \\ \text{NEVADA} \end{array} \times \begin{array}{c} \text{ESTIMATED \% OF} \\ \text{PEOPLE CONSIDERED} \\ \text{SED/AMI/SMI} \end{array} = \begin{array}{c} \text{PEOPLE IN NEVADA NEEDING} \\ \text{AND ELIGIBLE FOR PUBLIC} \\ \text{MENTAL HEALTH SERVICES} \end{array}$$

**Step 2:** To identify the unmet need of people in Nevada that required behavioral health services and were eligible to receive them through public provision, yet did not, the following formula was used:

$$\begin{array}{c} \text{PEOPLE IN NEVADA} \\ \text{NEEDING AND ELIGIBLE} \\ \text{FOR PUBLIC} \\ \text{BEHAVIORAL HEALTH} \\ \text{SERVICES} \end{array} - \begin{array}{c} \text{NUMBER OF PEOPLE WHO} \\ \text{ACCESSED PUBLIC BEHAVIORAL} \\ \text{HEALTH SERVICES} \end{array} = \begin{array}{c} \text{PEOPLE IN NEVADA NEEDING AND ELIGIBLE} \\ \text{FOR PUBLIC BEHAVIORAL HEALTH SERVICES} \\ \text{BUT NOT RECEIVING THEM (UNMET NEED)} \end{array}$$

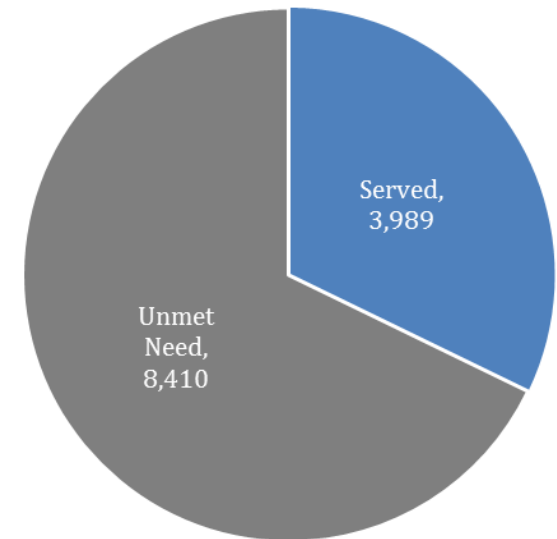


# Unmet Need: Children

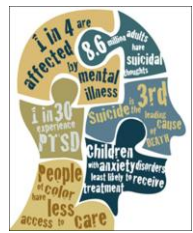


In Fiscal Year (FY) 2011-2012, there were a total of 12,399 children in the state that were Medicaid eligible and estimated to have a serious emotional disturbance (SED).

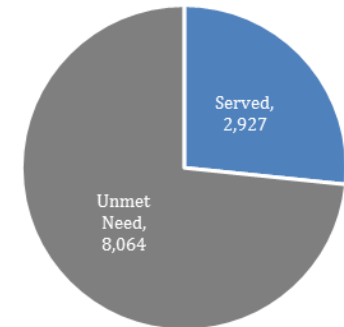
Of that total, the state provided services to 3,989 in FY 2011-12, representing 32% of the estimated need.



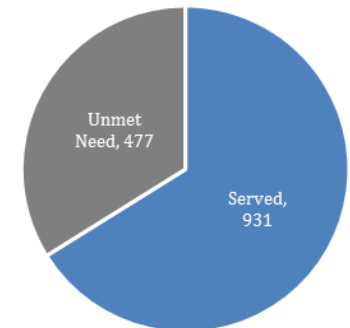
# Unmet Need: Children



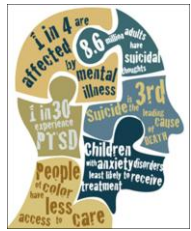
DCFS's service population totaled 10,991, of which 2,927 were served, representing approximately 27% of the estimated need.



DPBH's service population totaled 1,408, of which 931 were served, representing approximately 66% of the estimated need. A total of 477 (34%) children were estimated to be in need of but not receiving services in FY 2011-12.

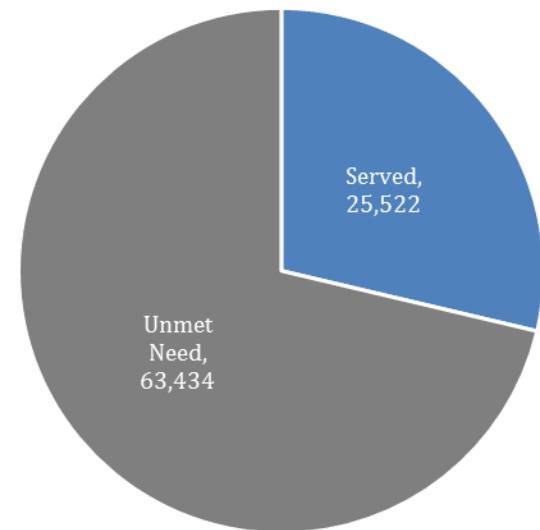


# Unmet Need: Adults

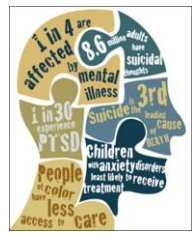


There are a total of 88,956 adults in the state of Nevada that are Medicaid eligible and are considered to have any mental illness (AMI) or a severe mental illness (SMI).

Of that total, DPBH provided services to 25,522 in FY 2011-12, representing 29% of the total of those estimated to be in need.



# Unmet Need: Consumer Survey



A Consumer Survey was issued to identify how people access services, their satisfaction with services received and identification of gaps in the service delivery system.

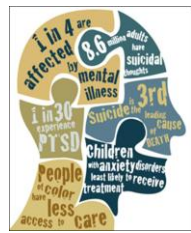
Surveys were distributed throughout the state to social service providers that did not provide behavioral health services.

Providers included food pantries, family resource centers and health and human service organizations.

A total of 339 individuals completed the survey.

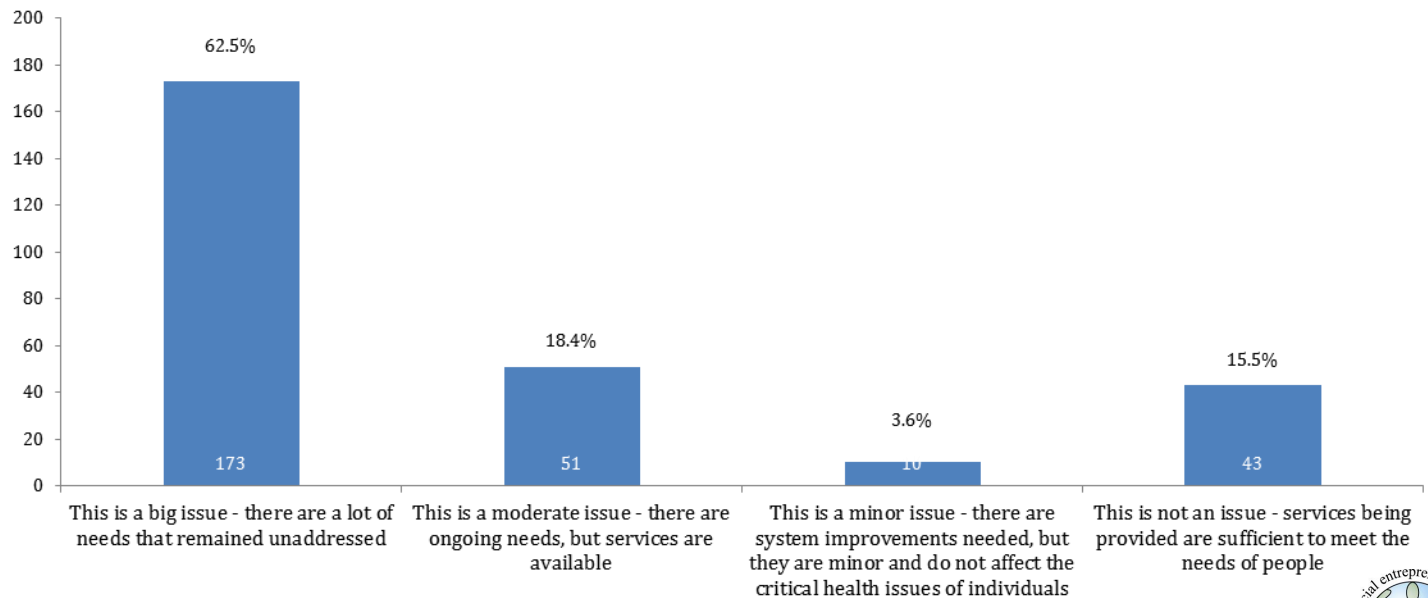


# Unmet Need: Consumer Survey

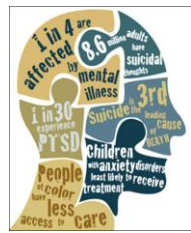


62% of those who responded indicated that behavioral health concerns were a big issue in their community with a lot of needs that remain unaddressed.

**Significance of Behavioral health Care for Your Community? (n=277)**

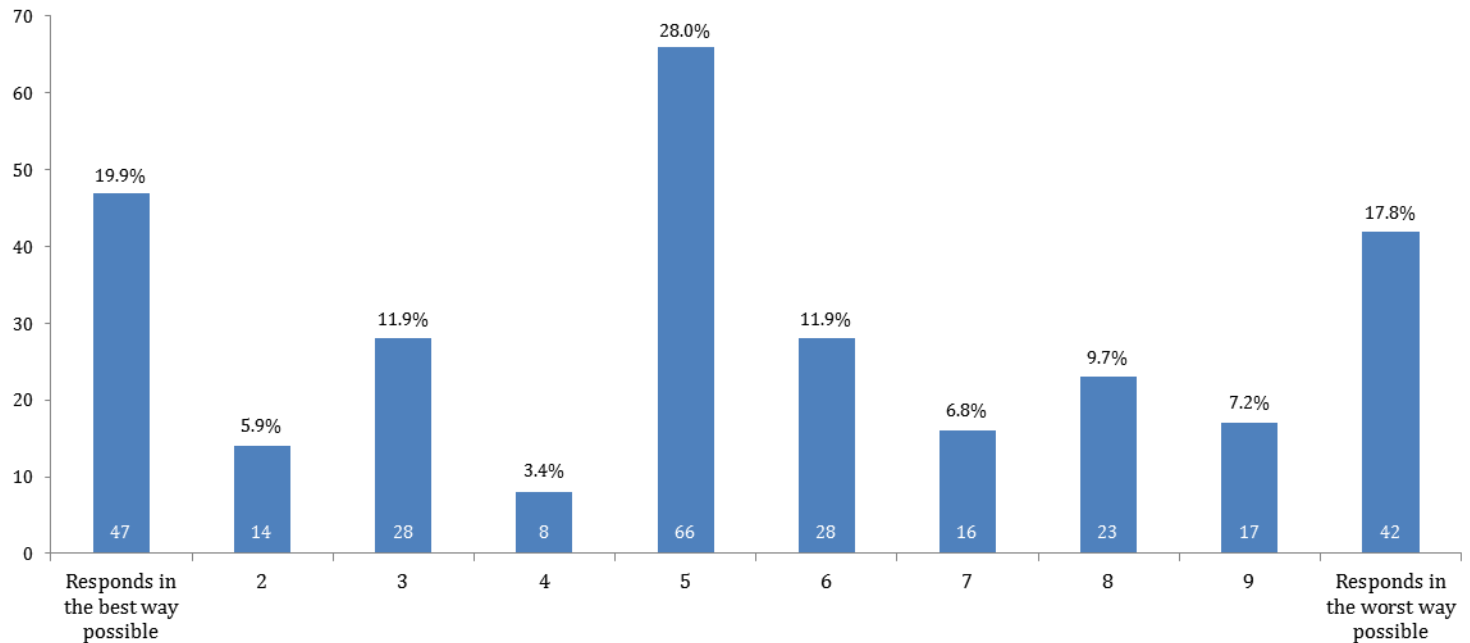


# Unmet Need: Consumer Survey



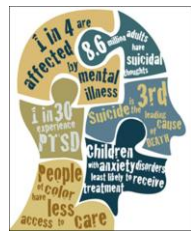
Respondents varied in how well they rated the current system in responding to the behavioral health care needs of the community.

How well current system responds to behavioral health care needs of your community?  
(n=236)

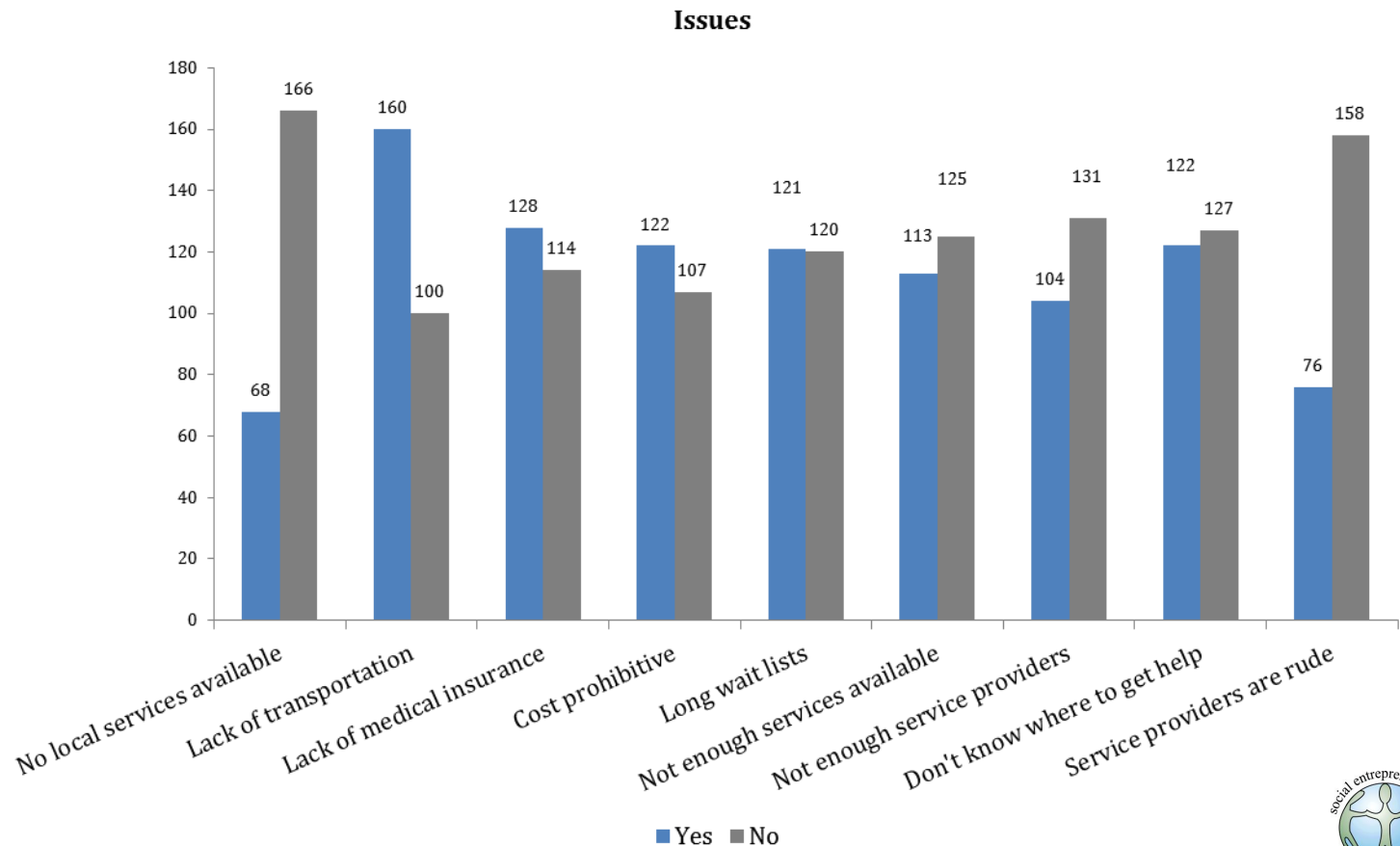




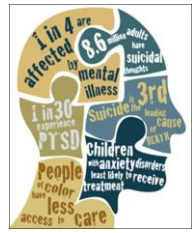
# Unmet Need: Consumer Survey



Respondents were given a list and asked to indicate whether the issue was a concern or barrier for them.



# Unmet Need

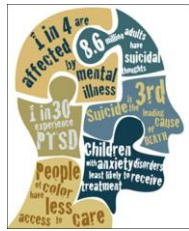


## Data Indicates:

- Services are currently reaching people in their middle stages of life, with insufficient resources for prevention or early intervention.
- Services are not sufficient to meet the needs of people later in life.
- A culturally competent framework to provide services to Nevada's growing minority population is needed.
- Insufficient service reach is most pronounced in the southern region of the state, as indicated by statistics that reveal only 24% of people eligible and needing assistance are being served.



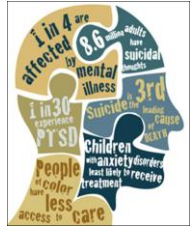
# Gaps in Services



While statistics were combined with existing publications to identify **what** gaps exist in the public behavioral health system, information gathered through key informant interviews and consumer surveys was used to explain **why** gaps in services exist.



# Gaps in Services

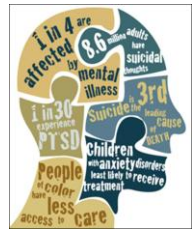


Key informants identified a number of weaknesses that need to be addressed to strengthen the system.

- Workforce
- Provider Network
- Resources
- Competing Priorities



# Gaps in Services

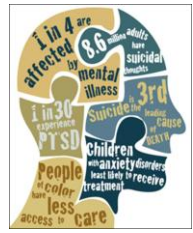


The following threats were identified that pose challenges to the system if not adequately addressed:

- Credibility
- Loss of Funding
- Staffing Shortages
- Housing
- Substance Abuse Services



# Gaps in Services

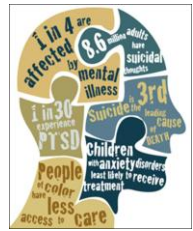


The following gaps were also noted:

- Lack of bilingual staff and specialty providers
- Uneven access to types and quality of services depending on location in the state
- Lack of resources for children, teens and seniors
- Transportation challenges
- Difficulty in obtaining services when in crisis



# Gaps in Services

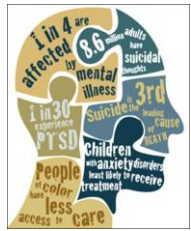


Statements from Key Informant Interviews signify the issues facing the Behavioral Health System:

- The “private mental health provider community hasn’t evolved like other states” because of the state operated system.
- Even the most sophisticated service providers describe the, “impossibility of getting an involuntary commitment in northern Nevada.”
- “There is a lack of supportive housing for those who can’t live independently but don’t need to be locked up.”
- “For those in mental health court, for a year, they receive intensive support. Once they are discharged, that support often ends.”
- “I worry that instead of fully integrating substance abuse and mental health that the good parts of mental health will feel the impact.”



# Gaps in Services

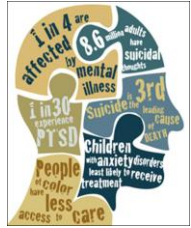


Intervention once law enforcement is involved is the norm





# Recommendations

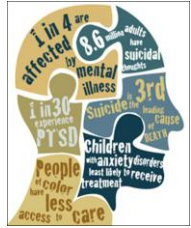


Nevada has an opportunity to implement a behavioral health system that is community-based, comprehensive and efficient. The gaps analysis is intended to assist the state in understanding gaps and taking steps to address them. To do so, three focus areas are recommended.

- Ensure accountability, credibility and high quality services.
- Develop community and state capacity to implement no wrong door
- Establish a vision and plan for the system of care and secure the resources necessary to implement the plan



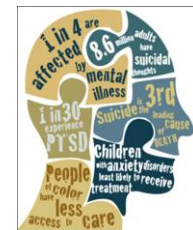
# Recommendations



When designing a system of care, a number of specific components are needed and detailed below:

- Prevention/Education
- Identification, Outreach and Access
- Assessment and Evaluation
- Behavioral Health Treatment
- Housing
- Coordination with Health Care
- Care Management
- Crisis Response Service
- Protection and Advocacy
- Peer Support
- Social Rehabilitation





*“There is a consequence for our whole community when people need services and can’t get them. We have an opportunity to intervene early in the process and provide services or we can leave it unaddressed and that portion of the populations is less happy, less productive and possibly dangerous. We do no kindness by letting folks suffer with their mental illness.”*

Key Informant Comment



# Questions/Comments?

